STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005006	A. BUILDING: _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	1007 LINCOLNWAY LA PORTE, IN 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of two State hospital complaints. Complaint Numbers: IN00135170 Substantiated: no deficiencies cited. IN00138679 Unsubstantiated: lack of sufficient evidence. Date: 3/10/14 Facility Number: 005006 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor Indiana University Health LaPorte Hospital is in compliance with 410 IAC 15-1.5-4, Medical record services, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Indiana Hospital Licensure Rules. QA: claughlin 04/04/14	S 000		